

§ 489.11

42 CFR Ch. IV (10–1–08 Edition)

(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and recipients of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Age Discrimination Act and 45 CFR part 90; and

(4) Other pertinent requirements of the Office of Civil Rights of HHS.

(c) In order for a hospital, SNF, HHA, hospice, or RNHCI to be accepted, it must also meet the advance directives requirements specified in subpart I of this part.

(d) The State survey agency will ascertain whether the provider meets the conditions of participation or requirements (for SNFs) and make its recommendations to CMS.

(e) In order for a home health agency to be accepted, it must also meet the surety bond requirements specified in subpart F of this part.

(f) In order for a home health agency to be accepted as a new provider, it must also meet the capitalization requirements specified in subpart B of this part.

[58 FR 61843, Nov. 23, 1993, as amended at 59 FR 6578, Feb. 11, 1994; 63 FR 312, Jan. 5, 1998; 68 FR 66720, Nov. 28, 2003]

§ 489.11 Acceptance of a provider as a participant.

(a) *Action by CMS.* If CMS determines that the provider meets the requirements, it will send the provider—

(1) Written notice of that determination; and

(2) Two copies of the provider agreement.

(b) *Action by provider.* If the provider wishes to participate, it must return both copies of the agreement, duly signed by an authorized official, to CMS, together with a written statement indicating whether it has been adjudged insolvent or bankrupt in any State or Federal court, or whether any insolvency or bankruptcy actions are pending.

(c) *Notice of acceptance.* If CMS accepts the agreement, it will return one

copy to the provider with a written notice that—

(1) Indicates the dates on which it was signed by the provider's representative and accepted by CMS; and

(2) Specifies the effective date of the agreement.

[45 FR 22937, Apr. 4, 1980, as amended at 59 FR 56251, Nov. 10, 1994; 62 FR 43937, Aug. 18, 1997]

§ 489.12 Decision to deny an agreement.

(a) *Bases for denial.* CMS may refuse to enter into an agreement for any of the following reasons:

(1) Principals of the prospective provider have been convicted of fraud (see § 420.204 of this chapter);

(2) The prospective provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter;

(3) The prospective provider is a physician-owned hospital as defined in § 489.3 and does not have procedures in place for making physician ownership disclosures to patients in accordance with § 489.20(u); or

(4) The prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(b) [Reserved]

(c) *Compliance with civil rights requirements.* CMS will not enter into a provider agreement if the provider fails to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90, subject to the provisions of § 489.10.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 34833, Sept. 30, 1986; 54 FR 4027, Jan. 27, 1989; 59 FR 6578, Feb. 11, 1994; 59 FR 56251, Nov. 10, 1994; 72 FR 47413, Aug. 22, 2007]

§ 489.13 Effective date of agreement or approval.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare—

(i) Are subject to survey and certification by CMS or the State survey agency; or